THE OMSIP HANDBOOK

ONTARIO MEDICAL SERVICES INSURANCE PLAN

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ONTARIO MEDICAL SERVICES INSURANCE PLAN
135 St. Clair Avenue, West, Toronto
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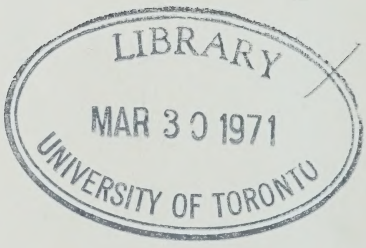
This information handbook has been prepared specifically for the doctor's office as a guide to claim filing and a reference to general information concerning the Ontario Medical Services Insurance Plan.



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GENERAL INFORMATION

Eligibility for Benefits

Residents of Ontario may apply for the standard medical services insurance contract from the Medical Services Insurance Division, Department of Health, 135 St. Clair Avenue West, Toronto 7.

This contract entitles the holder and his eligible dependants to the benefits provided by OMSIP from the effective date of the contract.

Premium Assistance

Assistance in paying Ontario Medical Services Insurance premiums is available on a yearly basis. PREMIUM ASSISTANCE can be applied for by anyone who is eligible under the OMSIP plan, and who qualifies on the basis of TAXABLE INCOME for the year ending December 31 last. To be eligible to apply for Premium Assistance a person must have lived in Ontario for the past 12 months or more.

Premium Assistance must be applied for annually.

CATEGORY	FULL PREMIUM SUBSCRIBER PAYS	ASSISTED PREMIUM SUBSCRIBER PAYS	ASSISTED PREMIUM ONTARIO GOVERNMENT PAYS
(1) SINGLE Covers one individual	$60.00 a year ($15.00 every 3 months)	$30.00 a year ($7.50 every 3 months)	$30.00 a year
(2) COUPLE Covers the contract holder and one dependant	$120.00 a year ($30.00 every 3 months)	$60.00 a year ($15.00 every 3 months)	$60.00 a year
(3) FAMILY Covers a family of three or more	$150.00 a year ($37.50 every 3 months)	$60.00 a year ($15.00 every 3 months)	$90.00 a year

Note: Residents of Ontario who had no taxable income for the year ended December 31st last are entitled to free OMSIP coverage provided they have fulfilled 12 months residency requirements.

Eligibility for Premium Assistance

Following are some of the points that determine eligibility for Premium Assistance:

(1) **Residency**—applicants must have lived in Ontario for the past 12 months.

(2) **Taxable Income**—Premium Assistance is based on the TAXABLE INCOME of contract holder and his eligible dependants for the year ending December 31 last.

(3) **Dependants**—All eligible dependants must be listed on contract holder's application. Blood relatives other than the contract holder's own children, *born or adopted*, are NOT eligible dependants. Not included as dependants are nieces, uncles, cousins, grandparents, grandchildren, etc.

(4) **Under 21**—If under the age of 21 and self-supporting, applicant must supply a statement from parent or guardian that he is NOT listed as a dependant on their income tax form.

(5) **Married Women**—If her husband is not willing or able to apply for an OMSIP contract, and she is eligible for Premium Assistance, she may apply for herself and children, providing she shows the COMBINED taxable income of her family including that of her husband.

(6) **Tax Exempt**—If a person does NOT pay Income Tax due to membership in a religious or charitable society or community, application can not be made for Premium Assistance.

Taxable Income

TAXABLE INCOME is NOT the total earnings of the contract holder and his dependants for the year. TAXABLE INCOME is the reduced amount of money on which tax is paid AFTER taking off any exemptions for dependants (wife, children, etc.) and other exemptions (medical expenses, charitable donations, etc.)

Note—Where more than one tax return is filed in one year, by a contract holder and his eligible dependants, he must combine the individual taxable incomes for the family and show TOTAL TAXABLE INCOME on the application.

Dependant

A "dependant" means a resident who is

(i) the spouse of the head of a family, or

(ii) a child of the head of a family who is dependant for support upon the head of the family and who is under the age of twenty-one years and unmarried.

Temporary Assistance

If at any time a person is temporarily unable to pay his OMSIP premium because of unemployment, illness or disability, assistance in the payment of the premium is available. Temporary Assistance may be granted for a period of 3 months, through application directly to the Ontario Medical Services Insurance Council at OMSIP.

Temporary Assistance forms are available from OMSIP and must be completed within 30 days of the due date of premium payments.

Social Assistance Benefits

If a person receives benefits through the Department of Social and Family Services, or through his local Municipal office, he should contact his social worker regarding his eligibility for free OMSIP coverage.

Note to Senior Citizens

There are two types of government pensions the senior citizen may receive:

(1) **Old Age Assistance** provided by the Province of Ontario. If a pensioner receives this pension he is automatically provided with free OMSIP coverage. The OMSIP registration card is automatically sent to Social Assistance recipients. If he has not received his OMSIP registration card, he should contact his social worker regarding his eligibility for free OMSIP coverage.

(2) **Old Age Security**—provided by the Government of Canada. If a person receives this pension (Old Age Pension), he should make application directly to OMSIP for a Standard Medical Services Insurance Contract . . . and for any Premium Assistance for which he might be eligible.

PROVISIONS

Registration Card

A registration card showing a contract number is issued to the contract holder. This means that the contract holder and his eligible dependants are entitled to the benefits provided under the standard contract.

Contract not Assignable

The benefits of the contract are provided for the contract holder and his eligible dependants and may not be transferred or assigned.

Basis of Payment for Benefits

The basis of payment for benefits under a standard contract are based on 90 per cent of the Ontario Medical Association's 1967 Schedule of Fees as authorized by The Medical Services Insurance Act, 1965.

Coverage under Standard Contract and by Statute

A contract holder who is covered by a standard contract and who receives, or is to be compensated for, medical or surgical care or services under any provincial enactment or any enactment of any other jurisdiction, is not entitled to standard contract benefits to the extent that he has received, or is to be compensated for, such care or services under such enactment.

Coverage under Additional Contract

A contract holder who makes a claim for benefits, and who has in force any other contract which provides benefits for medical expenses that are covered by the standard contract, has his standard contract benefits reduced by the amount of benefits payable under the other contract.

CONTRACT CHANGES

Additional Dependants

The Ontario Medical Services Insurance Plan requires registration of new-born or adopted children.

A new-born or adopted child must be registered with the Medical Services Insurance Division in order to receive benefits under the insurance contract. Providing that application is made within 30 days of birth or adoption, benefits commence from the date of birth or adoption. If the application is made after the first 30 days of birth or adoption, benefits for the additional dependant become effective three months following the date of registration.

A dependant child who has been registered under a Standard Medical Services Insurance Contract and who is taken into the custody of a Child Welfare Agency, receives continuous medical services insurance coverage if application is made on his behalf by the Agency within 30 days of custody transfer.

The OMSIP form, "Application for Addition of Dependant Child", is available at any Chartered Bank, Obstetrical Departments of General Hospitals, Physicians' offices and Welfare Agencies, as well as at OMSIP, 135 St. Clair Avenue West, Toronto 7.

Change in Dependant Status

A dependant covered under a standard contract, who marries prior to the age of 21, loses his dependant coverage and may make application for a standard contract for his wife and himself which becomes effective immediately on receipt of the application and subscription if the same is received within 30 days of the marriage.

Change in Address and Number of Dependants

The contract holder must notify the Medical Services Insurance Division of any change in his address, or of any change in the number of dependants covered under the standard contract.

Action by Contract Holder

A Contract Holder who brings an action to recover for loss or damages arising out of the negligence or other wrongful act of a third party in respect of which injury or disability, medical services insurance benefits have been provided under the standard contract, to the contract holder and his eligible dependants, shall include a claim on behalf of the Division for the cost of the standard medical services insurance benefits. Where a contract holder does not bring such an action against the third party, the Division may bring an action to enforce the Division's subrogation rights.

Release of Subrogation Rights

A release by the contract holder of any right respecting medical services insurance benefits to which the Division is subrogated is not binding on the Division unless the Division consents to such a release.

Cancellation of Contracts

OMSIP coverage may be cancelled by the Medical Services Insurance Division only:

(a) for misrepresentation or fraud as to a material fact;

(b) for non-payment of premiums. Subscribers who are unable to continue to pay for all, or part, of their OMSIP premiums due to unemployment, illness or disability may, however, apply to the Ontario Medical Services Insurance Council for continued membership on a social assistance basis (provided they apply within 30 days of receipt of notice after cancellation);

(c) where the contract holder ceases to be a resident, in which event coverage terminates ninety days after the date of ceasing to be a resident; or

(d) for misuse of services for which benefits are provided.

BENEFITS AND EXCLUSIONS

Benefits

Exclusions

Benefits

OMSIP pays at established rates for practically all doctors' services, including:

- doctor visits in the home, office or hospital;
- diagnosis and treatment of illness and injuries and the treatment of fractures and dislocations;
- diagnosis, pre-operation care and treatment, surgery and post-operation care; anaesthesia and X-rays for diagnostic, surgical and other procedures;
- certain dental surgical services performed in a hospital;
- obstetrical care, including prenatal and post-natal care effective from the date of enrolment;
- certified specialist services (psychiatric, paediatric).

The following 24 surgical procedures are standard contract benefits if performed in a hospital by a dental surgeon who has been appointed to the dental staff of such hospital on the recommendation of the chief of the surgical staff and with the agreement of the Medical Advisory Committee of such hospital:—

1. Surgical removal of teeth, erupted, unerupted or impacted.
2. Alveoloplasty and gingivoplasty.
3. Sulcus deepening and ridge construction.
4. Exposure of tooth for orthodontic treatment.
5. Treatment of traumatic injuries to soft tissues within the mouth.
6. Root resection.
7. Incision and drainage of abscess of dental origin.
8. Frenectomy.
9. Closed reduction of fractures of mandible and maxilla.
10. Excision of intra-oral cysts.
11. Intra-oral biopsy.

12. Excision of benign intra-oral tumours.
13. Removal of root or foreign body from maxillary antrum.
14. Repair and closure of antro-oral fistula.
15. Closed reduction of tempero-mandibular dislocation.
16. Sialolithotomy.
17. Excision of ranula.
18. Open reductions of fractures of the maxilla.
19. Open reduction of fractures of the mandible.
20. Surgical correction of prognathism or micrognathia.
21. Condylectomy.
22. Therapeutic or diagnostic alcohol nerve block.
23. Avulsion of nerve (mental, infra-orbital or inferior dental).
24. Open reduction of tempero-mandibular dislocation.

Exclusions

1. (a) Services that a covered person is entitled to receive under The Workmen's Compensation Act or similar legislation in any other jurisdiction.
   (b) Services that a covered person receives under any Act of this Legislature or under any enactment of any other jurisdiction.
   (c) Services for which no charge would be made in the absence of insurance.
2. (a) Laboratory and other diagnostic procedures rendered as hospital services to the extent that these are provided for under the plan of hospital care insurance under The Hospital Services Commission Act, and laboratory services and clinical pathology other than those authorized or ordered by a physician, billed by a physician and performed under the direction of a physician, subject to any limitations imposed by the regulations.

(b) Dental care for dental purposes, including X-ray and anaesthetist services; nursing services; ambulance services; dressings and cast materials; use of operating plaster or fracture rooms; drugs, vaccines, biological sera or extracts or their synthetic substitutes; eye glasses; special appliances; oxygen; physical therapy and other similar treatments.

3. Physician's services rendered to a covered person where the physician is paid to provide the services.
4. Services with respect to conditions that, in the opinion of a physician, are not detrimental to the health of a covered person, including services for cosmetic purposes only.
5. Expenses for travelling time or mileage.
6. Advice by telephone.
7. (a) Any services or examinations for the purpose of:
   (i) An application for insurance or under a requirement for keeping insurance in force;
   (ii) An application for admission to or continuance at or in a school, college, university, camp or an association;
   (iii) Employment, or the continuance of employment, or pursuant to the request of an employer or other person in authority;
   (iv) A passport, visa or other similar document.

   (b) Any similar examinations other than for the health of the person covered.
8. Group inoculation or inoculations pursuant to a statute or by-law or regulation thereunder.
9. Examination of the eyes by refraction.
10. Services rendered by a physician pursuant to an arrangement for rendering services to the employees of an employer or to members of an association.

Note: *OMSIP does not pay for cost of hospitalization. OMSIP is an additional service, not a substitute for hospital insurance; this is obtained through the Ontario Hospital Services Commission.*

SUBMISSION OF OMSIP ACCOUNTS

Payment

(a) If the physician wishes payment to be made directly to himself, the completed claim card *only* (marked "PAY DOCTOR") should be sent to OMSIP in the envelopes supplied. Please see note below.

If the physician wishes payment to be made to the patient, the completed claim cards may be:

1. submitted to OMSIP marked "PAY PATIENT". (Note: any statement to the patient for services rendered should bear a notation that the account has been submitted to OMSIP on the patient's behalf. This avoids duplication of claim filing);
2. sent to the patient, together with the letterhead account, for submission by the patient to OMSIP.

(b) If the physician does not wish to use OMSIP claim cards he may:

1. send an itemized account on his own letterhead to the patient, who in turn is responsible for submitting it to OMSIP. The letterhead account should provide:
   - OMSIP contract number
   - Contract holder's last name
   - Patient's first name
   - Patient's year of birth
   - Patient's sex
   - Diagnosis
   - Itemized services, with fees
   - Date(s) of service
   - Name of referring physician if any

The statement should be signed by the physician in writing or by a certified signature stamp. OMSIP transcribes this information to a card for processing of the claim. Only the last month of services is transcribed from continuous accounting systems *unless otherwise clearly indicated.*

Note 1: In "Pay Doctor" accounts where any attachment, i.e. doctor's account, is submitted with a claim card, payment will be made automatically to the subscriber.

Note 2: If claims are submitted on letterhead accounts payment is always made direct to the subscriber regardless of any other direction.

Deceased Contract Holder (pay patient)

When submitting a claim please indicate, when possible, the name and address of the person looking after the affairs of the deceased.

Cyclical Payments to Physicians

Payments to physicians and clinics are on a cycle basis, with the provision for ten payment runs each month. Each physician and clinic has a cycle number from 1-10 and from the month of July 1967 forward the time of payment is determined by this cycle number. Each of these numbers corresponds, roughly, to a date within the month, i.e. cycle 1, about the 3rd, cycle 2, the 6th, up to cycle 10 which falls on or about the 30th, of the month.

The determination of the cycle number is based upon the physician's number as follows:

Cycle		Range of Phys. Nos.	
1	3rd	010000—024999	
2	6th	025000—039999	
3	9th	040000—054999	
4	12th	055000—069999	(Phys. No.—The 1st.
5	15th	070000—084999	5 digits only are
6	18th	085000—099999	significant—the 6th.
7	21st	100000—114999	is a check digit)
8	24th	Open for future use	
9	27th	Open for future use	
10	30th	Clinics and Dentists	

Each page covers approximately 1500 doctors, with the exception of cycle 7 which presently contains about 1100. By leaving cycles 8 and 9 open it is possible to add extensively to the number of doctors participating and if necessary to split the clinics into two groups. It also permits a certain amount of flexibility in the scheduling of the payment runs.

It was felt to be desirable to keep the clinics' payments at the month end as it seems unlikely that the larger clinics would alter their billing dates whereas an individual doctor may find it to his advantage to do so if it hastened his remittance.

Claim Cards

There are three claim cards; each for a specific purpose. The white card is for the use of the physician. The white card with mauve band is for the use of Hospital Departments, Private Laboratories and Radiology Departments. The white card with yellow band is for dental claims covering the twenty-four in-hospital surgical procedures which are OMSIP benefits.

1. The White Card

A supply of claim cards stamped with the physician's (or physician group's) name, address and payee code number together with the necessary claim filing instructions are supplied to all physicians registered in Ontario. Return envelopes are supplied.

The last two digits of the OMSIP payee code number indicate the physician's qualifications as recorded by the College of Physicians and Surgeons.

e.g. 00—designates General Practitioner
13—designates Internal Medicine
03—designates General Surgery

Note: To ensure receipt of prompt and correct payment OMSIP should be notified immediately of any changes affecting a physician's practice, i.e. specialty, partnership, address, etc.

Enter, in space provided,

- Contract Number
- Contract Holder's Surname
- Patient's Given Name
- Patient's Year of Birth
- Patient's Sex

The diagnosis, procedures (and any laboratory tests) performed by the doctor should be entered in space designated "Diagnosis". If added space is necessary, there is a section on the reverse of the card "For Physician's Use". Where complicated procedures are involved and further explanation is necessary, an explanatory report should accompany the claim card.

Enter in the calendar space provided the date of each service using the appropriate code letters listed on the card (i.e. "H" Hospital Visit, "O" for Office Call). Cards are designed for two months of service only.

List number of calls and fees submitted in the designated spaces.

If the patient was referred, give the initials and surname of the referring physician in the space marked. Consultation fees can only be paid if the name of the referring physician is given.

In the space provided please record if possible "yes" or "no" for the inquiries, "Is this a Workmen's Compensation Case?" and "Is other Medical Services Insurance involved?"

Enter date when card was completed in the space provided. The physician's signature in writing or by certified signature stamp must appear in the space designated.

Record "yes" or "no" in spaces provided under Certified Specialist, whether the doctor is or is not a certified specialist.

Note: Under The Medical Services Insurance Act 1965 a certified specialist is:

(i) a legally qualified medical practitioner in Ontario who holds a certificate from the Royal College of Physicians and Surgeons of Canada certifying that he is a specialist in the care or services that are normally considered to include the care or services in question; or

(ii) a legally qualified physician practising outside Ontario who holds a certificate from the appropriate authority in the jurisdiction in which he practises certifying that he is a specialist in the care or services that are normally considered to include the care or services in question.

Billing of Laboratory Tests and Office Procedures

1. Laboratory tests *done by the physician in his own office* should be so specified.
2. Haemoglobin and dip-stick urinalysis are considered to be part of a normal visit, and no fee should be charged for them unless they are the sole reason for the visit. (Page 22, OMA Schedule of Fees 1967).
3. The physician may charge for a venipuncture when the blood specimen is forwarded to a laboratory for the actual performance of tests.
4. If a physician is charged for laboratory tests, the name of the laboratory is to be specified as well as the name of test done.
5. Diagnostic and Therapeutic Procedures should be listed using the terminology of the OMA Schedule.

List 1 contains those items which may constitute an extra service frequently performed during a visit, but are not necessarily part of a routine examination.

When done in conjunction with a general or specific assessment or a consultation, the first $4.00 worth of these procedures should not be charged when done by the physician performing the assessment.

When done in conjunction with a partial assessment or subsequent visit, the first $2.00 should not be charged. Over and above these amounts the charge should be listed for the group of procedures performed.

List II: Procedures in this list should be charged at half fee when done in conjunction with a consultation or a specific or general assessment.

When done in conjunction with a subsequent visit or partial assessment the procedure fee should be charged in full but the visit fee should not be charged, (by the physician performing the assessment).

List III comprises those items in which the full fee should be payable in addition to the visit or consultation fee.

2. The White Card with Mauve Band

Mauve banded cards are for the billing of laboratory diagnostic services for out-patients:—i.e. laboratory procedures, x-rays, electrocardiograms, electroencephalograms, isotope procedures, and pulmonary function tests.

The mauve banded cards are imprinted with the name, address and OMSIP payee code number of the particular department or laboratory concerned.

1. Enter, in space provided,
    - Contract Number
    - Contract Holder's Surname
    - Patient's Given Name
    - Patient's Year of Birth
    - Patient's Sex
    - Date(s) of Service
2. Individual tests are to be entered under space marked "Procedure". As abbreviations vary greatly, OMSIP requests that the full name of the laboratory test be supplied except in the case of such common abbreviations as: HB, C.B.C. or B.U.N. In the event that more than one test is entered on a single line, list the total fees for those tests on the same line.
3. Radiology claims will be paid at the routine view rate unless added information is provided on the cards.
4. If tests are sent from one laboratory to another, the name of the second laboratory should be stated and the fee charged by them should be the submitted fee.
5. The names of newer procedures which do not appear in the Schedule should be written in full and billed at the rate charged by the particular laboratory.
6. Please record "yes" or "no" if possible in the spaces provided for the inquiries, "Are these services covered by any other insurance plan?" and "Were services performed due to an automobile accident?"

7. The name of the physician who ordered the tests, or services, is to be entered on the card in the space marked "Registered Physician".
8. The date when the account is completed is to be recorded in the space provided.
9. The name of the physician who is the signing officer for the department concerned is to be entered in writing, or by stamp, in space marked "Authorized Signature".

3. White Card with Yellow Band

for the use of dental surgeons

1. A supply of claim cards stamped with the dentist's name, address and payee code number together with the necessary claim filing instructions are supplied to all dental surgeons registered in Ontario.
2. Return envelopes are supplied.
3. The last two digits or the OMSIP payee code number indicate the dental surgeon's qualifications as recorded by the Royal College of Dental Surgeons of Ontario.

   e.g. 00—designates Dental Surgeon
   02—designates Orthodontist
   04—designates Periodontist

Note: To ensure receipt of prompt and correct payment OMSIP should be notified immediately of any changes affecting a dentist's practice, i.e. specialty, address, etc.

4. Enter in spaces provided
   - Contract Number
   - Contract Holder's Surname
   - Patient's Given Name
   - Patient's Year of Birth
   - Patient's Sex

   Enter in spaces provided
   - Date of Service
   - Name of hospital patient admitted to

5. The diagnosis should be entered in the space provided. Where complicated procedures are involved a further explanation is necessary, an explanatory report should accompany the claim card.
6. The procedure performed by the dentist should be entered in the spaces provided together with the service number as shown on the reverse side of the claim card and fee submitted.
7. Use chart on reverse side of the claim card (if applicable) and mark teeth involved with "X".
8. In the spaces provided please record if possible "yes" or "no" for the inquiries.
   "Is this a Workmen's Compensation Case?"
   "Is other Medical Service Insurance involved?"
9. Enter date when card was completed in the space provided.
10. The dentist's signature in writing or by stamp must appear in the space designated.
11. Check whether payment is to be made to dentist or contract holder.

Note: The Ontario Medical Services Insurance Plan (OMSIP) includes provision only for the payment, at established rates, for any of the 24 dental surgical procedures (listed on the reverse side of the claim card) *where they have been performed in hospital* by a dental surgeon who has been appointed to the dental staff of such hospital by the Board of the hospital on the recommendation of the Chief of the Surgical Staff and with the agreement of the Medical Advisory Committee of such hospital.

MEMORANDA

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CODE NO. B231

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